Electronic Data Interchange (EDI) Trading Partner Profile – Provider Change

State Form 51406 (7-03)
Indiana State Department of Health

Provider of Service:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Software Vendor:

____ Purchased (please complete the information below) ____ Developed in-house (do not complete below)

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Billing Service or Clearinghouse Information:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

___ Health Care Claim (837)
___ Prior Authorization (278)
___ Eligibility Request (270)
___ Claim Status Request (276)
___ Additional Patient Information (275)
___ Retail Pharmacy Prior Authorization (NCPDP)
___ Retail Pharmacy Claim (NCPDP)
___ Retail Pharmacy Eligibility Request (NCPDP)

Outbound (sent from ISDH to you):

___ Payment Advice (835)
___ Prior Authorization (278)
___ Eligibility Request (271)
___ Claim Status Request (277)
___ Retail Pharmacy Prior Authorization (NCPDP)
___Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

___ Asynchronous Dial-up

___ **FTP** via PPP Dial-up Connection

Outbound Transaction Transmission

All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing all outbound transactions be sent to my intermediary listed above _____
Provider's Initials

_____ _____

Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:

ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803